Statewide Transformation Initiative
Involuntary Treatment Act (ITA) Review
Preliminary Findings and Options for Reform

Submitted to

The State of Washington
Department of Social and Human Services
Health and Recovery Services Administration
Mental Health Division

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I. Executive Summary

Involuntary treatment, including civil commitment, is perhaps the most divisive and controversial topic within the mental health stakeholder community. Within Washington State, stakeholders present a broad range of strongly-held and often conflicting viewpoints – ranging from the belief that involuntary treatment should never be imposed to the view that involuntary treatment should be provided whenever mental health professionals believe that a person is in need of treatment and the person is unwilling to receive treatment voluntarily.

Primary Findings. Despite this range of opinions, however, stakeholders share certain important beliefs about civil commitment in Washington. In particular, there is a broad consensus that:

- The use of civil commitment generally reflects a lack of sufficient appropriate, recovery-oriented community services, and that developing these services would lead to an overall decline in the need for civil commitment.

- The actual statutory language of Washington's involuntary treatment laws has less impact on the use of civil commitment than other factors, especially the lack of housing and community residential options.

There is no "model" statute or approach to civil commitment that is implemented by a majority of states. Rather, every state has a unique set of definitions and criteria based on the state's specific policy objectives and available resources. Nonetheless, a review of statutes from a sample of comparison states reveals the following about the Involuntary Treatment Act (ITA) found at §71.05 of the Revised Code of Washington (RCW):

- **Definition of "mental disorder."** Washington's statutory definition of "mental disorder" is broader than that of most other states in that it is not limited to specific diagnoses or types of mental illness and does not specifically exempt certain categories of impairments such as developmental disabilities. Most stakeholders in Washington State agreed that this broad definition is a significant concern because it results in the civil commitment of people who are not appropriately or effectively treated in a psychiatric setting.

  This provision in the law could be narrowed to include only certain mental illnesses or to exclude specific conditions that are not appropriately treated in psychiatric hospitals.

- **Definition of "gravely disabled."** Washington is among approximately half of states that permit civil commitment under a "gravely disabled" or similar standard based on the person's need for treatment as perceived by professionals or others. Washington's law defines "gravely disabled" as a person who is experiencing severe deterioration in routine functioning, as evidenced by repeated and

escalating loss of cognitive or volitional control, and who is not receiving care that is essential for their health or safety.

This law could be amended to permit civil commitment only when a person is a danger to themselves or others and is unable to care for their essential needs such as food and shelter. As an alternative, the law could be modified to permit civil commitment only when a person meets existing gravely disabled criteria *and* their judgment is so impaired by their mental illness that they are unable to make an informed decision about their own treatment. Another possible approach would be to permit commitment only when the person's deterioration is likely to result in their meeting other civil commitment criteria (danger to self or others) and/or hospitalization.

Many consumers and advocates, including Protection and Advocacy attorneys, support modifying this law to narrow the grounds for civil commitment, but most indicated that this is not as important to them as developing an appropriate community-based system of care that would eliminate the need for involuntary treatment. Many other stakeholders, including providers, family members, and prosecutors experienced with civil commitment, oppose significant modifications to this law.

Age of Consent for Minors. Some providers and parents of minor children with mental disorders are concerned about provisions in the state's law regarding mental health services for minors that permit minors over 13 years to consent to mental health treatment. In particular, they believe that this law may also give minors the ability to refuse treatment even when their parents and mental health professionals believe it is in their best interests. The law specifically permits parents to initiate treatment on behalf of these minors, but this law, found at RCW §71.34.600, is not used. More research is needed to better understand stakeholder concerns and to clarify why providers and parents are reluctant to use the parent-initiated treatment law.

Other Issues Outside the Scope of This Study. Stakeholders expressed several additional concerns related to the ITA that are outside the scope of the current review. The most important of these is the statutory procedure for the involuntary administration of psychotropic medications, which a broad range of stakeholders agree should be examined and possibly reformed.

Before implementing any changes to the ITA or other involuntary treatment laws, Washington should consult with and carefully consider implications for consumers and other service systems, including criminal justice, developmental disabilities, and long term care.

Next Steps. Additional research, key informant interviews, and two additional focus groups will be conducted prior to completion of the final report for this project, which will be submitted in June, 2007.

II. Introduction

The Washington Department of Social and Health Services (DSHS) Mental Health Division (MHD) has engaged TriWest Group (TriWest) to conduct a review of the Involuntary Treatment Act (ITA) in Washington State. Specifically, TriWest was asked to perform the following tasks:

- Review specific provisions in state involuntary treatment statutes;
- Compare specific provisions with other states' approaches; and
- Identify strengths, challenges, and options for reform.

TriWest Group partnered with Advocates for Human Potential, Inc. (AHP) to conduct primary research and initiate development of the preliminary and final report under this project. Focusing on key provisions identified by MHD, this preliminary report provides an overview of research to date, a preliminary comparison of Washington's statute with other states' approaches, and preliminary analysis that identifies strengths, challenges, and specific options for reform. This report also includes a brief overview of specific issues of concern that were raised by multiple stakeholders during the initial research phase of this project.

Throughout this report, specific areas recommended for additional research are identified in blue. These research questions, along with other "next steps" discussed in Section IX, will be the focus of additional study over the next three months. A final report in connection with this project will be submitted in June, 2007.

Project Overview

The ITA review is being conducted in connection with four other studies as part of an overall Strategic Transformation Initiative (STI) being led by MHD. Other components of the STI include:

- Funding for Programs of Assertive Community Treatment (PACT), including training and technical assistance to support implementation;
- Review of Washington's benefits package for adults and children with mental disorders;
- Development of a mental health housing plan; and
- Development of an inpatient utilization review protocol.

MHD appointed a multi-stakeholder Task Force to provide input on STI activities, including the ITA review.

Research Methods

Research methods employed in the development of this preliminary report include: (1) general literature review and legal research regarding the evolution of state civil commitment laws, noting implications for hospital utilization; (2) solicitation of input

from the Task Force regarding the scope and focus of the project as well as specific recommendations for reform; (3) extensive use of key informant interviews, including national experts and stakeholders within Washington State; and (4) use of focus groups to explore additional detail in particular areas of concern.

Appendix A includes a list of key informants interviewed for this review, as well as the names of focus group participants.

Project Scope

In guiding TriWest/AHP's work in connection with this project, MHD emphasized that the ITA review is driven, in significant part, by the following policy objectives: (1) to create a recovery-focused, resiliency-based system of care in the community; and (2) to ensure that utilization of inpatient services is necessary and appropriate. The analysis presented in this preliminary report is grounded in these important policy objectives.

The term "involuntary treatment" is very broad, and could be interpreted to mean involuntary outpatient commitment (also called "assisted treatment" by some advocates), involuntary medications, or other interventions deemed by consumers to be coercive. For the purposes of this review, the discussion of "involuntary treatment" will focus principally on inpatient civil commitment.

A critical issue to be examined in this report, which emerged from discussions with the STI Task Force and other stakeholder meetings, is the definition of "mental disorder" in the statute. In addition, MHD staff directed TriWest/AHP to focus its review on the following issues:

- Definition of "grave disability" in Washington's civil commitment statute; and
- Washington's "age of consent" for receiving mental health services, including a review of the law permitting parent-initiated treatment.

Forensic laws regarding the treatment of people with mental illness in the criminal justice system fall outside the scope of this review. However, research in connection with this report included meetings and key informant interviews regarding Washington's law requiring mandatory detention under the civil commitment laws of certain misdemeanants found not competent to stand trial ("forensic conversion"). A brief overview of this issue is presented in Section VI of this report.

Additional issues that were identified by several stakeholders or the authors as priorities for review are discussed briefly in Section VIII of this report, although a thorough analysis of these issues falls outside the scope of this report.

III. Background and Context for Review

Involuntary treatment, including civil commitment, is perhaps the most divisive and controversial topic within the mental health stakeholder community. In the course of this review, the authors considered a broad range of strongly-held and often conflicting viewpoints regarding civil commitment. For example, members of the STI Task Force's ITA Focus Group were asked to articulate, from their perspectives, the most important policy objectives or desired outcomes for reforms to Washington State's involuntary treatment laws. Their responses included:

Make civil commitment more available as a mechanism to divert people who will otherwise be involved in the criminal justice system	*and*	Narrow civil commitment laws to ensure that everyone who is civilly committed can benefit from hospitalization
Lower the threshold for commitment under the grave disability standard to make getting help easier	*and*	Raise the threshold for commitment under the grave disability standard to promote civil rights and minimize the use of inpatient services

Even within specific stakeholder groups, perspectives on involuntary treatment often vary. For example, many consumers participating in the Community Forum, Task Force, and other focus groups in connection with this review expressed a concern that involuntary treatment is traumatic, does not support recovery, and violates an individual's rights to liberty. Some shared personal stories that questioned whether civil commitment was appropriate in their case or whether the process used was fair. Other consumers interviewed for this review suggested that they benefited from involuntary treatment. One person, who was committed at Western State Hospital at the time of the interview, summarized the tension well, stating that he does not support the "gravely disabled" criteria under which he was committed, but added that his hospitalization resulted in a new treatment approach that would be beneficial to him in the community and help him to avoid interactions with the criminal justice system.

Despite this range of opinions, however, stakeholders share certain important beliefs about civil commitment in Washington. In particular, there is a broad consensus that:

- The use of civil commitment generally reflects a lack of sufficient appropriate, recovery-oriented community services, and that developing these services would lead to an overall decline in the need for civil commitment.

- The actual statutory language of Washington's involuntary treatment laws has less impact on the use of civil commitment than other factors, especially the lack of housing and community residential options.

Evolution of Commitment Criteria

Until the 1960s and 70s, most states permitted involuntary hospitalization based on a perceived need by clinicians and professionals that the individual needed treatment. During the 1970s, several Federal court decisions helped to spur a narrowing of most state laws to require dangerousness as a condition for involuntary hospitalizations.[1] In 1973, following a decision by the Washington Supreme Court that the state must prove by clear, convincing, and cogent evidence that a person is mentally ill and dangerous,[2] Washington enacted legislation permitting involuntary commitment only if a person (1) poses a likelihood of serious harm to himself or others; or (2) is gravely disabled. That legislation defined "gravely disabled" as a condition in which a person, as a result of a mental disorder, is "in danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety."[3]

Some Washington stakeholders were dissatisfied with the new law. In particular, family members said they were forced to abandon loved ones in order to meet the standard that the person being committed is unable to meet "essential human needs" such as food and shelter.[4] Some providers also expressed frustration at their inability to obtain commitment for people that they believed were in need of treatment but who were still able to meet essential human needs.[5]

In 1979, following a highly publicized double murder by a person with a mental illness, Washington became one of the first states to expand its definition of "gravely disabled" to include a criterion based on mental – not just physical – deterioration and a need for treatment.[6] Washington's definition of "gravely disabled" now includes a person who "manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety." Today, about half the states have a similar "need for treatment" criterion for civil commitment, although specific definitions and requirements vary from state to state.[7]

Washington's civil commitment statute (or ITA) is provided at RCW §71.05.

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[1] Miller, R.D., Involuntary Civil Commitment, in American Psychiatric Press, Review of Clinical Psychiatry and the Law, vol. 2, Simon, R.I. (editor) (1991). *See especially* Lessard v. Schmidt, 349 F. Supp. 1078, 1085-86 (E.D. Wis. 1972), *vacated and remanded for a more specific order*, 414 U.S. 473 (1974), *order on remand*, 379 F. Supp. 1376 (E..D. Wis. 1974), *vacated and remanded on other grounds*, 421 U.S. 957 (1975), *order reinstated on remand*, 413 F. Supp. 1318 (E.D. Wis. 1976).

[2] In re Levias, 83 Wn. 2d 253, 517 P.2d 588 (1973). For a brief history of involuntary commitment in Washington State through 1984, see Drumheller, B.L., *Constitutionalizing Civil Commitment: Another Attempt – In Re Harris*, 59 Wash. L.Rev. 375 (April, 1984).

[3] Drumheller, B.L. (1984). *Constitutionalizing Civil Commitment: Another Attempt – In Re Harris, 98 WN.2d 276, 654 P.2d 109 (1982).* 59 Wash. L. Rev. 375.

[4] Pierce, G.L., Durham, M.L. and Fisher, W.H. (1985). The Impact of Broadened Civil Commitment Standards on Admissions to State Mental Hospitals. 142 Am J. Psychiatry at 104-107.

[5] Id.

[6] The new law also restored "danger to property" as a component of the "likelihood of serious harm" criteria for commitment. Id. This provision is discussed briefly in Section VII of this report.

[7] See Treatment Advocacy Center, *State Standards for Assisted Treatment*, at www.psychlaws.org.

Civil Commitment Processes

Civil commitment processes are unique to every state but most – including Washington – permit a brief period of initial detention without a court hearing. Subsequent detentions generally require a court hearing, with substantial due process protections for the person who is the subject of the commitment petition. A brief summary of Washington's civil commitment process is attached to this report as Appendix B.

In general, Washington stakeholders seem satisfied with the commitment process provided in the statute. However, some stakeholders suggested that the process is not always applied as it is articulated in the law. In particular, consumers suggest that, although the statute clearly provides individuals with the right to participate in their commitment hearings, many are not informed of that right or are discouraged from participating. In addition, providers and consumers point out that the timeframes described in the statute often are extended, at least in part because appropriate placements either in the community or the state hospital are not available.

Less Restrictive Alternatives

Like virtually every state, Washington requires that less restrictive alternatives (LRAs) be considered before an individual may be civilly committed to an inpatient setting.[8] However, most courts across the country that have considered this issue agree that this requirement is applicable only where the services are available.[9] In the landmark case Olmstead v. L.C., the U.S. Supreme Court considered a related question: Does the Americans with Disabilities Act (ADA) require states to provide services to people with disabilities – including people with mental illnesses – in the most integrated setting appropriate for their needs? The Supreme Court's response was a qualified yes – services should be provided in the most integrated setting, but a state is not required to create new services to accomplish this.[10]

Some stakeholders suggested that not all judges are aware of the range of LRAs that may be available, and that LRAs should be used more frequently.

Research Issue: Review available data regarding the percentage of initial detentions resulting in LRAs and variation in the use of LRAs across RSNs.

[8] Levy, R.M. and Rubenstien, L.S. (1996). The Rights of People with Mental Disabilities (ACLU Handbook) at 33. Southern Illinois University Press: Carbondale and Edwardsville.
[9] Id.
[10] Olmstead v. L.C., 527 U.S. 581 (1999).

IV. Data Review

As background for this preliminary report, this section briefly discusses Washington's use of inpatient facilities relative to other states, state mental health authority spending on community services and inpatient services relative to other states, variation in commitment rates across RSNs, and a discussion of the impact that the broadening of the "gravely disabled" standard in 1979 had on commitment rates.

A. Inpatient Utilization

An important impetus for the ITA review is a general concern regarding Washington State's reliance on inpatient care at its two state psychiatric hospitals for adults. The Substance Abuse and Mental Health Services Administration, through its Uniform Reporting System (URS), collects national data regarding inpatient use in state hospitals. According to researchers who analyzed the most recent URS data, the data likely are flawed in that reporting states varied in whether they included forensic beds in their overall counts.[11] With that important caveat, the data suggests Washington maintains more state hospital beds per capita than other states do.

B. Inpatient Expenditures

The National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) collects data every two years regarding expenditures controlled by state mental health authorities. In 2004, the most recent year for which national data are available, Washington's expenditures for state hospitals were slightly higher than the national median. As a percentage of overall mental health spending controlled by the state's mental health authority, Washington's expenditures on state hospitals are just above the national rate of 28 percent.[12] With respect to community mental health spending controlled by state mental health authorities, Washington spends more than the national median and national average.[13]

C. Detention Rates and Variation across RSNs

A broad range of stakeholders – including providers, family members, and consumers -- identified variation among RSNs as a principal concern related to the ITA. In particular, some stakeholders suggested that Designated Mental Health Professionals (DMHPs) – professionals employed by the RSN and charged with the responsibility of carrying out assessments for initial detentions under the ITA – in King County RSN interpreted civil commitment criteria very narrowly and were much less likely than their counterparts in other RSNs to initiate an initial detention.

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[11] Telephone interview with Ted Lutterman, National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc., January 12, 2007.
[12] National Association of State Mental Health Program Directors Research Institute, Inc., *FY 2004 Revenue and Expenditure Study Results*, August, 2006.
[13] Id.

Representatives from King County RSN and the state association of DMHPs dispute that hypothesis, citing a 1999 study of DMHPs across the state, which found that perceptions of King County DMHPs[14] regarding whether an individual has met commitment criteria in a particular case generally match those of DMHPs in other counties.[15] However, nearly all stakeholders agree that the defense bar in King County is more aggressive in defending against civil commitments than in other regions of the state, possibly leading to reluctance by DMHPs to initiate initial detentions and by prosecutors to pursue 14-day and 90-day commitments.

Although the state collects data from RSNs regarding rates of initial detentions, there are some questions about the accuracy of the state's data and they are not presented here. However, a review of the available data suggests that detention rates do vary considerably across RSNs. The cause of the variation is not clear, although population and/or geographic location do not appear to account entirely for the variation.

It is important to note that whether or not civil commitment criteria are applied more narrowly in any given RSN, the mere *perception* that this is the case may actually have an important impact. In particular, the belief that a civil commitment order is hard to obtain may lead to police officers and prosecutors pursuing criminal charges in misdemeanor cases in order to detain a person who they believe needs evaluation or treatment.

D. Impact of 1979 Law

Following Washington's adoption in 1979 of broader criteria for civil commitment under the gravely disabled standard, Pierce, Durham, and Fisher reviewed the number of civil commitments and concluded that involuntary admissions to the state hospital nearly doubled in the year following enactment of the new law.[16] This study frequently is cited as evidence that a broadening of commitment criteria will result in an increase in the utilization of inpatient services.

However, the authors of that study also noted that the *total* number of admissions to state hospitals – both voluntary and involuntary – during that time increased by only about 30 percent.[17] Since the patient characteristics of people who were civilly committed did not change under the new law, the authors concluded that the most significant impact of the law was to "involuntarize" the process of admission for many people who might otherwise have been admitted voluntarily.

It seems logical to assume a change in inpatient utilization when a statute is altered, since the purposes of expanding or narrowing criteria generally include affecting the number

[14] Until 2005, DMHPs were employed by counties and were known as County Designated Mental Health Professionals, or CDMHPs.
[15] Fine, D. and Bell, M. (1999). King County Review of Standards for Detention. Unpublished document obtained from Amnon Shoenfeld, King County RSN.
[16] Pierce, G.L., Durham, M.L. and Fisher, W.H. (1985). The Impact of Broadened Civil Commitment Standards on Admissions to State Mental Hospitals. 142 Am J. Psychiatry at 104-107.
[17] Id. at Table 1.

and range of people who can be committed. However, the experience of Washington and some other states suggests that the actual application of civil commitment laws may depend not only on the language of the statute but also on other factors, such as the availability of housing and community services, aggressiveness of prosecutors and defense attorneys, and expectations of community members regarding non-conforming behavior.

In research published after the Pierce, Durham, and Fisher study, Miller observed that the steep increase in commitments began several months *before* the statute went into effect, suggesting that the increase in involuntary commitments may have been principally a reaction to the highly-publicized double murder rather than the change in the definition of "gravely disabled."[18] Miller reviewed data from seven other states that had adopted broader commitment statutes. He concluded that only two of those states experienced significant increases following the adoption of the new standards, and he offered alternative theories for those increases. In particular, he noted that the broadening of commitment criteria generally follows a high-profile tragedy or crime – as was the case in Washington – which often results in increases in civil commitment rates regardless of any change in statutory criteria.

These studies examine the impact of legislation broadening civil commitment criteria, with conflicting conclusions regarding the impact of these changes on inpatient utilization. We are not aware of any efforts to review the impact of legislation that narrows – rather than broadens – criteria for civil commitment. While it seems reasonable to expect that such a change would result in a decrease in civil commitments, the considerable variation that currently exists among states applying similar commitment criteria suggests that the outcome may be more complicated or nuanced than that.

[18] Id. at 1381.

V. Key Issues and Analysis

This section provides a discussion of two key provisions of the ITA identified by MHD and multiple stakeholders as priorities for review: (1) the definition of "mental disorder"; and (2) the definition of "gravely disabled". Each of these subsections includes an overview and analysis of the statutory text, a summary of stakeholder concerns, a comparison to other states' approaches, and a discussion of specific options for reform.

Comparison states were selected in collaboration with MHD on the basis of two principal factors: (1) geographic similarities, especially states with large rural areas and a few urban centers; and (2) similar financing structures. The comparison states are Arizona, Colorado, Iowa, Massachusetts, New Mexico, and Oregon.

In addition, this section will include a discussion of the age at which minors may consent to mental health treatment ("age of consent") and parent-initiated treatment, including an analysis of the statutory text, a summary of stakeholder concerns, and a discussion of additional research to be completed for the final report. Although this discussion will be informed by examples from other state laws, a formal review of comparison states will not be used to conduct the analysis.

A. Definition of "Mental Disorder"

Overview of Issue

Washington's statute defines "mental disorder" as "any organic, mental, or emotional impairment which has substantial adverse effects on a person's cognitive or volitional functions."[19] Although MHD did not initially direct TriWest/AHP to review this specific provision, stakeholders participating in Task Force meetings and key informant interviews repeatedly identified this definition as one of their most important concerns. As a result, MHD agreed that it should be a focus of review.

Specifically, the broad definition of "mental disorder" in the statute encompasses many people who may not have psychiatric illnesses, such as people with developmental disabilities, dementia, or traumatic brain injury (TBI). Nearly all stakeholders agreed that this leads to the civil commitment of people who are not appropriately served in state hospitals. Many stakeholders expressed a particular concern that Western State Hospital has become a provider of last resort for people with developmental disabilities.

Analysis

Defining "mental disorder" in the context of civil commitment is a policy issue, rather than a legal or medical issue. Many states use the term "mental disability" rather than "mental disorder," and it may refer to a comprehensive range of impairments that affect mental or cognitive functioning, including mental illnesses, developmental disabilities,

[19] RCW §71.05.020(22).

cognitive communication disorders, and substance abuse.[20] The DSM-IV uses the term "mental disorders" to include mental illnesses as well as mental retardation and various substance abuse disorders. The DSM-IV acknowledges:[21]

> [T]hat no definition adequately specifies precise boundaries for the concept of a "mental disorder." The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations ….

There is no model statutory definition or consistent approach used across states. In fact, every state defines the population of people who may be civilly committed differently through both the language of their statute and case law interpreting it. In general, "mental disorder," "mental disability," or even "mental illness" are likely to be defined in order to achieve specific policy objectives and to reflect policy decisions regarding the appropriate locus of services for people with specific mental or cognitive disabilities.

The following table summarizes the range of approaches to defining mental disorder in the comparison states. Four of the six states explicitly exclude people with developmental disabilities, to some extent, from their definitions.

Figure 2.

State Approaches to Defining Mental Disorder/Mental Illness in Civil Commitment Laws	
Arizona	"Mental disorder" means "a substantial disorder of the person's emotional processes, thought, cognition or memory. Mental disorder is distinguished from: (a) Conditions that are primarily those of drug abuse, alcoholism or mental retardation, unless, in addition to one or more of these conditions, the person has a mental disorder. (b) The declining mental abilities that directly accompany impending death. (c) Character and personality disorders characterized by lifelong and deeply ingrained antisocial behavior patterns, including sexual behaviors that are abnormal and prohibited by statute unless the behavior results from a mental disorder." *Ariz. Rev. Stat. §36-501(26).*
Colorado	"Person with a mental illness" means "a person with one or more substantial disorders of the cognitive, volitional, or emotional processes that grossly impairs judgment or capacity to recognize reality or to control behavior. Developmental disability is insufficient to either justify or exclude a finding of mental illness within the provisions of this article." *Colo. Rev. Stat. 27-10-102(8.5)*

[20] Parry, J. (1995). Mental Disability Law: A Primer, at 2-3. American Bar Association Commission on Mental and Physical Disability Law: Washington DC.
[21] Id., *citing* Diagnostic and Statistical Manual (DSM) IV.

State Approaches to Defining Mental Disorder/Mental Illness in Civil Commitment Laws	
Iowa	"Mental illness" means "every type of mental disease or mental disorder, except that it does not refer to mental retardation … [as defined elsewhere in the Iowa Code] or to insanity, diminished responsibility, or mental incompetency as the terms are defined and used in the Iowa criminal code …." *Iowa Code 229.1(9).*
Massachusetts	Statute requires a mental illness, but does not provide a statutory definition. *See Mass Gen. Laws ch. 123.*
New Mexico	"Mental disorder" means "the substantial disorder of the person's emotional processes, thought or cognition which grossly impairs judgment, behavior or capacity to recognize reality, but does not mean developmental disability." *N.M. Stat. Ann. 43-1-3(O).*
Oregon	"Mentally ill person" means a person who, because of a mental disorder, is one or more of the following: (A) Dangerous to self or others. (B) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety. (C) A person who: (i) Is chronically mentally ill ….; (ii) Within the previous three years, has twice been placed in a hospital or approved inpatient facility by the department …; (iii) Is exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the hospitalizations or inpatient placements …; and (iv) Unless treated, will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will [become a danger to themselves or others or be unable to provide for their basic personal needs]." *Or. Rev. Stat. § 426.005(1)(d).* Mental disorder is not defined in the statute.

Strengths

The breadth of the definition of "mental disorder" in Washington's civil commitment law provides flexibility for DMHPs, prosecutors, and others to ensure that people can be ordered for evaluation and treatment when necessary, regardless of specific diagnosis.

Challenges

The flexibility that could be considered a strength of Washington's definition of "mental disorder" may result in civilly committing to inpatient psychiatric services many people who cannot benefit from the treatment provided there. Very broad statutory language permits hospitals – especially state hospitals, but also to some degree community providers of psychiatric inpatient services – to become providers of last resort even when that approach is neither effective nor efficient. Once hospitalized, the ability to discharge the person to another setting is compromised by the inability of the facility to actively treat or otherwise affect the course of the disorder. Anecdotal evidence suggests that many people with developmental disabilities may have longer lengths of stay, further contributing to the concern that inpatient services in the state may be over-utilized.

To the extent that the definition of "mental disorder" contributes to inpatient hospitalization of people who cannot benefit from treatment and face significant obstacles to discharge, it undermines MHD's goal of creating a recovery-focused system of care that emphasizes community services where possible.

Options for Reform

There are a broad range of potential approaches to reforming Washington's statute to prevent the civil commitment of people who are not likely to benefit from the treatment available to them in inpatient psychiatric settings. All of them likely would put pressure on other service systems, and should be considered in the context of a broader strategy to meet the needs of people who would no longer be eligible for commitment under the statute. Ideally, that strategy would focus on providing effective and likely less expensive services in the community to minimize the need for institutionalization, whether voluntary or involuntary. However, a few stakeholders expressed the need for the state to create a secure facility for people with developmental disabilities who may pose a danger to themselves or others and who would otherwise be committed to state hospitals.

More information is needed regarding the actual diagnoses of people who are initially detained and/or civilly committed for long periods of time and their lengths of stay in order to tailor a specific statutory change to address the specific populations for which civil commitment is over-used or inappropriate. Two possible approaches to revising the statute are presented here.

1. **Change "mental disorder" to "mental illness" and define mental illness more narrowly.** Although neither term has a precise legal definition, some states permit civil commitment only for people with mental illnesses and attempt to define that in more narrow, clinical terms. For example, Pennsylvania defines mental illness as those "disorders that are listed in the applicable APA Diagnostic and Statistical Manual." Pennsylvania goes on to exclude some DSM diagnoses from the definition unless they co-occur with other qualifying conditions: "[P]rovided however, that mental retardation, alcoholism, drug dependence and senility do not, in and of themselves, constitute mental illness. The presence of these conditions however, does not preclude mental illness."

2. **Specifically exclude people with developmental disabilities or other conditions from the definition of "mental disorder."** Like Pennsylvania, several states make such an exclusion explicit in their statutes. For example, New Mexico has a fairly broad definition of "mental disorder" but specifically provides that mental disorder "does not mean developmental disability."

   Arizona's statute provides a useful approach to excluding a range of conditions from the definition of mental disorder while addressing the possibility that some of these conditions may co-occur with conditions that do meet the statutory definition:

> Mental disorder means a substantial disorder of the person's emotional processes, thought, cognition or memory. Mental disorder is distinguished from:
>
> (a) Conditions that are primarily those of drug abuse, alcoholism or mental retardation, unless, in addition to one or more of these conditions, the person has a mental disorder.
> (b) The declining mental abilities that directly accompany impending death.
> (c) Character and personality disorders characterized by lifelong and deeply ingrained antisocial behavior patterns, including sexual behaviors that are abnormal and prohibited by statute unless the behavior results from a mental disorder.

Washington's own statute governing mental health services for minors also limits the range of conditions considered to be a "mental disorder." The statutory definition mirrors the language in §71.05 but goes on to provide that: "The presence of alcohol abuse, drug abuse, juvenile criminal history, antisocial behavior, or mental retardation alone is insufficient to justify a finding of "mental disorder" within the meaning of this section."[22]

Research Issue: Explore lengths of stay for people with DD and other non-psychiatric disorders at state hospitals.

B. Definition of "Gravely Disabled"

Overview of Issue

All states permit the involuntary commitment of people with mental illnesses who pose a danger to themselves or others, and most also permit the commitment of people who are so "gravely disabled" by their illness that they are unable to meet essential human needs. As discussed in Section III above, following a national trend toward more restrictive civil commitment laws, Washington was one of the first states to expand its definition of "gravely disabled" to permit the civil commitment of a person who is experiencing a physical or mental deterioration in functioning that threatens the person's health or safety, even if the person's essential needs such as food and shelter are met. Washington's statute defines "gravely disabled" as the following:[23]

> [A] condition in which a person, as a result of a mental disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning evidence by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety.

[22] RCW §71.34.020(13).
[23] RCW §71.05.020(16)

About 62 percent of the total number of people reported to be detained under the involuntary treatment laws in Washington State during FY2006 were considered to be "gravely disabled."[24] It is not clear from available data how many of these individuals may also have been considered committable on the grounds that they also posed a danger to themselves or others, as more than one reason was provided for as many as 1,100 of the detentions recorded.[25]

Stakeholder views on Washington's definition of "gravely disabled" vary significantly, and often reflect the stakeholder's broader views on the efficacy and ethics of all forms of involuntary treatment. Most consumers consulted in the initial research for this project felt that the current definition is too broad, and several provided the authors with examples of instances in which they felt it was used inappropriately. For example, one person currently committed to Western State Hospital said he believed that he was committed principally because he was homeless and expressed the fear that he would again be either arrested or detained under the civil commitment law because he did not have a stable home. Concerns about the inappropriate use of the "gravely disabled" criteria as a means of civilly committing people also were echoed by defense attorneys and the state's protection and advocacy agency. Family members, on the other hand, said that even the broad definition in current law makes civil commitment of loved ones too difficult.

Despite the range of perspectives on the definition of "gravely disabled," however, there is a virtual consensus among stakeholders on two inter-related points. First, stakeholders believe that the language of the statute is less important than how it is applied, and they suggested that variability among counties and RSNs be studied and addressed. Second, stakeholders agree that the most important "reform" the state should implement is to provide effective, recovery-oriented, and resiliency-based services in the community to minimize, if not eliminate, the need for civil commitment and other forms of involuntary treatment. Stakeholders agree that if such a community-based system were in place, civil commitment would be used far less frequently regardless of the specific language in the statute.

Analysis

Most states permit civil commitment for individuals who are considered to be "gravely disabled," although many states use a different term or simply embed the criteria in other definitions. As discussed above, there is no "model" statutory definition or consistent approach used across states, so a review of any law should consider whether it is effective in achieving a given state's policy objectives.

The following table summarizes the range of approaches used to define "gravely disabled" or similar civil commitment criteria in the comparison states:

[24] Data provided by DSHS MHD (e-mail correspondence from Judy Hall, dated 1/25/07).
[25] Data collected by MHD provide 7,747 reasons for the total 6,586 72-hour detentions reported in 2006.

Figure 3.

State Approaches to Defining Gravely Disabled in Civil Commitment Laws	
Arizona	"Gravely disabled" means "a condition evidenced by behavior in which a person, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because he is unable to provide for his basic physical needs." *Ariz. Rev. Stat. §36-501 (16).* In addition, "persistently or acutely disabled" means "a severe mental disorder that meets all of the following criteria: (a) If not treated has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional or physical harm that significantly impairs judgment, reason, behavior, or capacity to recognize reality. (b) Substantially impairs the person's capacity to make an informed decision regarding treatment and this impairment causes the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment and understanding and expressing an understanding of the alternatives to the particular treatment offered after the advantages, disadvantages and alternatives are explained to that person. (c) Has a reasonable prospect of being treatable by outpatient, inpatient or combined inpatient and outpatient treatment. *Ariz. Rev. Stat. §36-501(33).*
Colorado	"Gravely disabled" means "a condition in which a person, as a result of a mental illness: (I) Is in danger of serious physical harm due to his or her inability or failure to provide himself or herself with the essential human needs of food, clothing, shelter, and medical care; or (II) Lacks judgment in the management of his or her resources and in the conduct of his or her social relations to the extent that his or her health or safety is significantly endangered and lacks the capacity to understand that this is so. *Colo. Rev. Stat. 27-10-102(5)(a).* The statute specifically permits a finding of gravely disabled where a person is not in danger of harm because of care provided by a family member if there is notice that the support is to be terminated and the individual meets several additional criteria, including treatment for specific diagnoses of mental illness and/or recent, repeated hospitalizations. *Colo. Rev. State. 27-10-102(5)(b).*
Iowa	No specific "gravely disabled" provision, but "seriously mentally impaired" means "the condition of a person with mental illness and because of that illness lacks sufficient judgment to make responsible decisions with respect to the person's hospitalization or treatment, and who because of that illness meets any of the following criteria: … (c) Is unable to satisfy the patient's needs for nourishment, clothing, essential medical care, or shelter so that it is likely that the person will suffer physical injury, physical debilitation, or death. *Iowa Code 229.1 (16).*
Massachusetts	No specific "gravely disabled" provision, but "likelihood of serious harm" includes "a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community. *Mass. Gen Laws ch. 123 §1.*

State Approaches to Defining Gravely Disabled in Civil Commitment Laws	
New Mexico	"Grave passive neglect" means failure to provide for basic personal or medical needs or for one's own safety to such an extent that it is more likely than not that serious bodily harm will result in the near future. *N.M. Stat. Ann. 43-1-3(K).*
Oregon	No specific "gravely disabled" provision, but "mentally ill person" includes a person who, because of a mental disorder, is one or more of the following: … (B) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety. (C) A person who: (i) Is chronically mentally ill ….; (ii) Within the previous three years, has twice been placed in a hospital or approved inpatient facility by the department …; (iii) Is exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the hospitalizations or inpatient placements …; and (iv) Unless treated, will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will [become a danger to themselves or others or be unable to provide for their basic personal needs]." *Or. Rev. Stat. § 426.005(1)(d).*

Of the comparison states, Arizona, Colorado, and Oregon – like Washington – permit civil commitment even when a person's essential needs, such as food and shelter, are met. The Treatment Advocacy Center, a national advocacy organization that generally supports broader civil commitment criteria, estimates that half of the states have this kind of statute permitting commitment when there is a "need for treatment."[26] Each of these states, however, imposes different criteria regarding when a person may be civilly committed under these circumstances.

For example, Arizona's relatively broad statute requires a person to have a severe mental disorder that, if not treated, has "a substantial probability of causing the person to or continue to suffer severe and abnormal mental, emotional or physical harm that significantly impairs judgment, reason, behavior, or capacity to recognize reality." In addition, the person must not be capable of making an informed decision regarding treatment, and the person's disorder must have "a reasonable prospect of being treatable."

In contrast, Oregon permits civil commitment for individuals who have prior hospitalizations and are exhibiting symptoms similar to those that led to earlier hospitalizations, but further requires a showing that, unless treated, the person will continue, "to a reasonable medical probability," to deteriorate until he or she is either a danger to himself or others or unable to meet essential needs.

Iowa, Massachusetts, and New Mexico do not permit civil commitment unless a person is unable to meet his or her essential needs which, in Massachusetts, means that the person is unable to protect himself in the community. The approach used in each of these states generally permits civil commitment only when the person's condition poses a danger to

[26] See Treatment Advocacy Center, *State Standards for Assisted Treatment* at www.psychlaws.org.

self or others, including the danger that could result from an individual's inability to meet his or her essential needs.

Strengths

Washington's definition of "gravely disabled" effectively addresses the specific concerns that led to its revision in 1979. Specifically, the statute permits the civil commitment of people whose are experiencing a severe deterioration in functioning and who are not receiving care essential for their health or safety -- even if other essential human needs are being met. This is an important concern for many family members who want to ensure that their loved ones receive treatment before they pose a danger to themselves or others.

Other stakeholders have suggested that a broader law permits more flexibility to address individual needs on a case-by-case basis. For example, one King County prosecutor told the authors of this report: [27]

> A common theme here is that even though the grounds for commitment are present, a DMHP does not necessarily need to detain. However, if you shrink the available grounds for commitment, a DMHP will be unable to detain, even when the need to detain is great.

Challenges

Washington's statutory definition of "gravely disabled" is broader and, on its face, permits civil commitment under more circumstances than in most states. As discussed above, it is not clear how the breadth of statutory definitions and civil commitment criteria affects rates of civil commitments in any given state, but it is reasonable to assume that narrowing the law may lead to a reduction in the number of commitments and related inpatient admissions.

Options for Reform

Several state examples provide options for reforming the definition of "gravely disabled" within Washington's civil commitment statute:

1. **Repeal 71.05.020(16)(B).** One approach to reform would be to repeal the 1979 amendment to the statute that permits civil commitment, even when a person's essential needs such as food and shelter are met, if the person is experiencing severe deterioration in routine functioning and is not receiving care essential for his or her health or safety. Such an approach likely would be supported by many, but not all, consumers, advocates, and Protection and Advocacy and defense attorneys. Many other stakeholders, including families, police officers, prosecutors, providers, and DMHPs likely would oppose such a change, arguing

[27] E-mail correspondence from Ethan S. Rogers, Jr. Senior Deputy Attorney, ITA Unit – Civil Division, King County Prosecuting Attorney's Office (Feb. 23, 2007).

that this would delay intervention and treatment, with negative consequences both for the individual and community safety.

2. **Modify 71.05.0200(16)(B).** Several possible amendments to the gravely disabled definition could help to narrow the law while still permitting commitment before a person poses a danger or is unable to care for themselves. These include:

   - **Narrowing the law to permit civil commitment only when the person is unable to make their own informed judgment about treatment.** Arizona's statute, for example, includes such a requirement.

   - **Including a requirement that the person's deterioration is likely to result in the person becoming a danger to themselves or others.** Although Oregon's statute permits civil commitment of a person before they become a danger to themselves or others, it requires a showing that, "to a reasonable medical probability," the deterioration will continue until the person meets other statutory civil commitment criteria.

   - **Including a requirement that the person's deterioration is likely to result in the person requiring hospitalization.** Oregon's statute permits civil commitment where a person has been previously hospitalized and is exhibiting behaviors and symptoms similar to those that resulted in prior hospitalizations.

C. Age of Consent: Impact on Parent-Initiated Treatment

In Washington, a minor 13 years or older may admit themselves to an evaluation and treatment facility for inpatient treatment without parental consent.[28] If the professional person in charge of the facility agrees that the minor needs inpatient treatment because of a mental disorder, the facility provides the type of evaluation and treatment needed, and it is not feasible to treat the minor in a less restrictive setting, the minor may be admitted.[29] A minor who initiates inpatient treatment in this way may give written notice of intent to leave at any time and, in general, must be discharged from the facility at that time.

Similarly, a minor 13 years or older may request and receive outpatient mental health services without parental consent.[30] The law requires parental notification when a minor is admitted to an inpatient facility and when he or she is discharged, but notification is not required when the minor receives outpatient services at his or her request.

Washington is not unique in permitting teenaged minors to request and receive mental health services without the consent of the minor's parent. Several states give minors the explicit authority to consent to outpatient mental health services. None of these states specifically requires parental consent to obtain these services, and many do not generally

[28] RCW §71.34.500.
[29] Id.
[30] RCW §71.34.530.

require parental notification. Some states, such as California[31] and New Mexico,[32] permit minors as young as 12 years old to consent to mental health treatment. Several states, such as Connecticut, permit minors 14 years and older to consent to treatment.[33]

In general, the focus groups and interviews conducted with Washington stakeholders in connection with this report have not suggested broad dissatisfaction with the ability of minors 13 years and over to request and receive either outpatient or inpatient services without their parent's consent. However, some stakeholders expressed concern that these rights to consent to treatment may imply a related right to refuse treatment even when the minor's parents or mental health professionals believe treatment is in the person's best interests.

The Washington legislature apparently tried to address these concerns directly with adoption of a statute permitting "parent-initiated treatment" of a minor child of any age. This law (RCW §71.34.600) permits a parent to take his or her minor child to an appropriately licensed facility (as defined by statute) and request that the minor be examined to determine whether he or she has a mental disorder and is in need of inpatient treatment.[34] If the parent takes the minor to the facility, the minor's consent is not required for admission, evaluation, and treatment. An evaluation should be completed within 24 hours, although that time period may be extended for a total of 72 hours if the professional person[35] conducting the evaluation believes additional time is necessary.

It is important to note that a minor admitted to an inpatient facility through this parent-initiated process is considered a voluntary patient, whether or not the minor objects to the admission. As a result, the standard for admission is whether the minor has a mental disorder and whether he or she is in need of treatment and the admission is medically necessary. There is no requirement that the minor pose a danger to self or others or that he or she be gravely disabled. In addition, the statute specifically provides that, while a provider is not required to conduct an evaluation or admit a minor under this parent-initiated process, the provider may not refuse to provide treatment solely because the minor objects. Similarly, the minor may not be discharged solely on the basis of his or her request.

Despite the statutory provision permitting parent-initiated treatment, stakeholders contacted in connection with research for this preliminary report generally said that the process is not used. This is consistent with legislative findings in 2005, which stated: [36]

> The legislature finds that, despite explicit statements in statute that the consent of a minor child is not required for a parent-initiated admission to inpatient or

[31] Cal. Civ. Code §25.9.
[32] N.M. Stat. Ann. §32A-6-12.
[33] Conn. Gen. Stat. §17-205f.
[34] RCW §71.34.600.
[35] Professional person is defined by the statute to mean a physician or other mental helaht professional empowered by an evaluation and treatment facility with authority to make admission and discharge decisions on behalf of the facility. RCW §71.34.010(18).
[36] RCW §71.23.600, *Finding – Intent* – 2005 c 371 §1.

> outpatient mental health treatment, treatment providers consistently refuse to accept a minor aged thirteen or over if the minor does not also consent to treatment. The legislature intends that the parent-initiated treatment provisions, with their accompanying due process provisions for the minor, be made fully available to parents.

The legislature also amended the statute, apparently to address provider concerns about legal risk or liability, by adding the following section:[37]

> A minor child shall have no cause of action against an evaluation and treatment facility, inpatient facility, or provider of outpatient mental health treatment for admitting or accepting the minor in good faith for evaluation or treatment under [the parent-initiated treatment provisions of the statute] based solely upon the fact that the minor did not consent to evaluation or treatment if the minor's parent has consented to the evaluation or treatment.

It is not clear why the parent-initiated treatment provisions of the statute are not more widely used. One possible explanation is a lack of clarity regarding the procedure available to minors who refuse treatment. A minor who is admitted for evaluation or treatment under the statute authorizing parent-initiated admission has the right to petition the Superior Court for release from the facility and must be informed of that right prior to the DSHS review.[38]

Although the statute provides a time frame for the petition – not sooner than five days following the DSHS review – no additional guidance regarding due process afforded the minor is provided. Representatives for some inpatient providers have suggested that this lack of specific direction regarding process deters them from admitting minors, since there is insufficient clarity about how minors can exercise their rights and the obligations of providers to facilitate this.

Another possible reason that the parent-initiated treatment law is not used may be a concern by providers about independent reviews of their admission decisions. The statute provides that DSHS review all parent-initiated inpatient admissions within seven to 14 days of the date that the minor was brought to the facility. The statute explicitly provides that the person conducting the review may not be affiliated with the facility or have a financial interest in continued inpatient treatment of the minor. If the reviewer does not agree that it is a medical necessity for the minor to receive inpatient treatment, the facility and parents will be notified and the minor must be discharged to his or her parents within 24 hours of their receipt of notice. Inpatient providers did not identify this review process as a source of concern during focus groups and key informant interviews conducted to date. However, it may be one reason that providers are reluctant to admit minors referred under the parent-initiated treatment provisions of the statute.

[37] RCW §71.05.660.
[38] RCW §§71.34.600(6), 72.34.620.

Research Issue: Continue to explore with a range of stakeholders why the parent-initiated treatment law is not used.

VI. "Forensic Conversion" and Implications for the ITA

A significant number of people who are civilly committed in Washington State began the commitment process through the criminal justice system. Under a process known as "forensic conversion," certain defendants who are found not competent to stand trial must be committed by the court to an appropriate facility for evaluation and treatment to attempt to restore their competency. Although an extensive review of this issue is outside the scope of this preliminary report, the implications of this law are significant for the ITA. Therefore, a brief overview of the law, issues, and current efforts to address them is provided here.

Criminal laws related to people with mental illness are provided at RCW §10.77. Under that chapter, if there is reason to doubt the competency of a defendant in criminal court, the court, the defendant, or the prosecutor may order a competency examination. The court may, but is not required to, order that the examination take place in a hospital or other appropriate mental health facility. An inpatient examination must be completed within 15 days of the defendant's admission to the facility.

If the defendant is found not to be competent, the court may be required under the statute to detain them for competency restoration:

- If the defendant is charged with a felony, they will be detained for evaluation and treatment until they regain the competency necessary to understand the proceedings against them, for a period of up to 90 days.

- If the defendant is charged with a misdemeanor and has (1) a history of one or more violent acts, or a pending charge of one or more violent acts; or (2) was previously acquitted by reason of insanity or was previously found incompetent under §10.77 or any equivalent federal or out-of-state statute with regard to an alleged offense involving actual, threatened, or attempted physical harm to a person, then they will be detained for a competency restoration period of up to 14 days plus any unused time from the 15-day competency examination period.

If, at the end of the competency restoration period, a defendant who is charged with a misdemeanor still is not competent to stand trial, the court must order them detained for a period of up to 72 hours for the purposes of filing a civil commitment statute under RCW §71.05.

Implementation of §10.77 is directly related to civil commitment under §71.05 in several ways, and reform of either law must be undertaken only with careful consideration as to how any changes will affect people who may be referred for civil commitment under either law. In particular, many stakeholders believe that a narrowing of civil commitment criteria under the ITA may lead to an increase in the number of people who are arrested for misdemeanors because police officers may feel that the criminal justice system provides a more accessible avenue for people to receive help.

Stakeholders have identified several important issues related to the statutory text of RCW §10.77 and implementation of the competency to stand trial and "forensic conversion" processes in Washington State. A few of these issues are described briefly below:

- **Timelines for conducting competency examinations and restoration attempts.** The statutory language regarding the timeframe during which a competency examination must take place is vague when the examination takes place in jail, as most examinations for misdemeanants are. Jail officials and judges in King County have complained that defendants may wait for days or even weeks for an examination.

- **Content of the competency examination report.** Section 10.77.060(3) requires the competency examination report that is submitted to the court to include all of the following components:

    1. A description of the nature of the examination;
    2. A diagnosis of the mental condition of the defendant;
    3. If the defendant has a mental disease or defect or is developmentally disabled, an opinion as to competency;
    4. If the defendant has indicated his or her intention to rely on an insanity defense, an opinion as to the defendant's sanity at the time of the act;
    5. When directed by the court, an opinion as to the capacity of the defendant to have the requisite state of mind that is an element of the offense charged; and
    6. An opinion as to whether the person should be evaluated by a DMHP for civil commitment under §71.05 and as to whether the defendant is a substantial danger to other persons or presents a substantial likelihood of committing criminal acts jeopardizing public safety or security.

    At a December, 2006 meeting of judges, prosecutors, defense attorneys, and advocates from King County and Western State Hospital administrators, most stakeholders agreed that much of the information required in the competency examination report is not directly relevant to an initial finding of competency. There was a general consensus among participants that the requirements for the report should be streamlined in order to speed up competency determinations and reduce the amount of time that people with mental illnesses are required to wait in jail.

    Location of Civil Commitment Evaluations. Currently, all competency restorations and 72-hour detentions ordered under §10.77 are conducted at the State hospitals, although this is not required by the statute. Many stakeholders complained that the 72-hour detentions and resulting "forensic conversion" commitments occupy a large number of State hospital civil beds, with the largest number coming from King County, contributing to a shortage of available beds. Representatives from Western State Hospital, local inpatient providers, and King

County RSN suggested that local hospitals lack the capacity to handle these detentions and/or that the cost of detaining people in local facilities is too high.

However, it may be advantageous to continue to explore ways to conduct at least 72-hour detentions for "forensic conversions" in local facilities. Such an approach would minimize the disruption that occurs when people are removed from their communities (and accompanying local, informal support systems) and admitted into State hospitals.

- **Use of Prior History.** At least one prosecutor commented on the difficulty of determining whether or not a defendant charged with a misdemeanor has a history of one or more violent acts that would require mandatory detention for competency restoration. Whether or not a person has committed a violent act is not always apparent from a review of their criminal record, and often requires additional research into the facts underlying previous charges. This may contribute to process delays that result in people with mental illnesses remaining in jail longer than is needed.

- **Mandatory Civil Commitment Evaluations for Misdemeanants.** Several stakeholders expressed dissatisfaction with the statute's requirement that a defendant with a history of one or more violent acts who is charged with a misdemeanor must undergo attempts at competency restoration, even if the crime they are charged with is not serious.

  In 2005, the Washington Supreme Court also struggled with this issue. In Born v. Thompson,[39] the Court applied a balancing test of interests to determine what the appropriate standard of proof should be in order to commit a person for competency restoration. The court found that, in the case of a misdemeanor crime for which penalties are relatively light, the court's interest in bringing the defendant to trial and the public safety interests were not strong. The court said that, in the case of people charged with misdemeanors, "[t]he individual liberty interest at stake here weighs more heavily in balance than the governmental interests in public safety and prosecution of misdemeanors." This imbalance was compounded, the court said, by a significant risk of an erroneous deprivation of liberty.

Several initiatives to review issues related to §10.77 and "forensic conversions" currently are underway in Washington State. One of these initiatives is a work group comprised of judges, prosecutors, defense attorneys, jail officials, and advocates from King County, along with representatives of the State Hospitals and MHD. Working with an outside consultant engaged by MHD, this group is working to achieve a consensus on ways to reduce the amount of time that people remain in jail waiting for a competency examination, streamlining the content of the competency examination report, and other issues.

[39] Born v. Thompson, 117 P.3d 1098 (Wash. 2005).

Washington's legislature also is exploring changes to §10.77 and §71.05. Senate Bill 5533 is designed to provide more opportunities for diversion of people with mental illnesses, either into appropriate voluntary outpatient programs or through civil commitment. Diversion options would be targeted for people who are charged with non-serious misdemeanors and who do not have a history of serious violent offenses. A second bill, Senate Bill 1691, was withdrawn from the hearing calendar and is not expected to be heard this session.

VII. Tribal Concerns and Implications

Representatives of Washington's Tribal governments have expressed concerns about the State's current approach to implementing involuntary treatment laws, which does not recognize the jurisdiction of Tribes to order civil commitment or authorize inpatient services at State hospitals. Although the scope of this project initially did not permit comprehensive research related to Tribal concerns and implications,[40] the principal author interviewed two DSHS Tribal liaisons and project staff participated in a 2/5/07 meeting with DSHS MHD and Tribal leaders from three of the State's 29 Tribal governments to review this project and other aspects of the Strategic Transformation Initiative.

Tribes in Washington have varying capacities and infrastructure to conduct assessments for detention or provide due process for individuals prior to ordering a 14-day or longer commitment period. Therefore, there may be a range of views among Tribes about whether they want to establish their own civil commitment criteria or be able to order commitments, including commitments to the state hospital. However, at least some Tribal representatives expressed the concern that they should be more involved in the civil commitment process for Tribal members who are detained from reservations or who will return to reservations when they are discharged from the hospital.

For example, according to one DSHS Tribal liaison, a Tribe that contacts a DMHP to request a 72-hour detention may or may not succeed in having the DMHP agree to conduct an assessment, depending on the Tribe's relationship with the RSN. Even if the RSN does send a DMHP and a 72-hour detention follows, the individual will be transported to a community hospital for an evaluation and, if the hospital petitions for a longer commitment period, the Tribe will not be engaged either in that process or in any subsequent legal processes related to the commitment. More important, according to some Tribal representatives, Tribes generally are not engaged – in contrast to RSNs – in planning for discharge from State hospitals.

At least one Tribal representative has suggested that RSNs should accept referrals for 72-hour detentions from Tribes, rather than "wasting resources" by engaging a DMHP to conduct an additional assessment. Such a change might require a revision to the statute, since current law generally requires DMHPs to serve as a gatekeeper for all 72-hour detentions.[41] Although it is not clear what impact such a change might have on the number of involuntary detentions in the State, it could raise new issues about whether detention criteria are applied uniformly, who would pay for detentions ordered by the Tribe, and where evaluations during the 72-hour detention period would be conducted.

[40] As discussed in Section IX. Next Steps, a separate chapter focused on the concerns of the 29 federally recognized Tribes in Washington State with the ITA and implications of any proposed changes has been added to the scope of work for this project and will be completed by June, 2007.

[41] 71.05.150 permits a police officer to initiate an emergency detention, but a DMHP must file a supplemental petition for detention within 12 hours.

Tribal liaisons interviewed in connection with this review suggested that, consistent with the sovereignty of Tribal governments, each Tribe should be permitted to negotiate agreements with the state that address that Tribe's unique needs, concerns, and capacities.

Many Tribal concerns may be related to the fact that, with a few exceptions for prevention-related programs, the State does not provide funding directly to Tribes to provide community mental health services to their members. While some Tribes may provide those services under contract with RSNs, this does not reflect a direct, government-to-government relationship between Tribes and the State. In addition, Tribal representatives noted that many Tribal programs are effective in preventing the need for people to access RSN services, and they suggested that Tribes should be compensated directly by the State for this. Some Tribal representatives also noted that, in order to be effective, services to American Indian/Alaska Natives must be culturally competent, and they suggested that Tribes are in a unique position to address this need.

While specific concerns regarding funding arrangements for community mental health services are beyond the scope of this review, they reflect important issues regarding the legal relationship between the State and Tribal governments. Because Tribes have historically high rates of mental illness, trauma, substance abuse, and suicide, it is critical that the State fully understand any legal or other implications of changes to the ITA on American Indian/Alaskan Natives, Tribal governments, or relationships between the Tribes and RSNs.

VIII. Other Relevant Issues

This section provides a very brief overview of several additional issues that were identified by stakeholders or the authors during the initial research phase of this project. These issues fall outside the scope of this review but remain relevant to Washington's ITA. Some of these issues suggest the need for additional research and/or statutory reform that may be addressed in other forums.

Involuntary Medication

Many consumers and advocates identified the involuntary administration of psychotropic medications under the ITA as their highest priority for reform. In particular, they expressed dissatisfaction with §71.05.215(1)(c), which permits the involuntary medication of a person receiving short-term treatment up to 30 days under a civil commitment order if there are two concurring medical opinions approving the medication. Legal experts in Washington representing both patients and hospitals agreed that the current law raises important constitutional questions.

There are a range of views regarding how this concern should be addressed – consumers suggest that the involuntary administration of medication should never be permissible unless supported by an advance directive, while some attorneys suggest that other state laws requiring hearings for the non-emergency administration of medications might provide models for reform. Despite these differences, however, the consensus that a significant issue exists suggests the need for further study and appopriate reform efforts.

Definition of Likelihood of Serious Harm

Washington's statute permits civil commitment of a person if there is a substantial risk that "physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others."[42] Most states do not permit civil commitment on the basis of danger to property, and this represents a significant deviation from the usual criteria of "danger to self or others." This provision provides an opportunity for reform, although none of the stakeholders involved in the initial research for this project indicated that this was a priority for them. More research is needed to know how frequently this is a basis for detention and/or inpatient admissions.

Advance Directives

RCW Chapter 71.32 specifically for the development and implementation of mental health advance directives. Many consumers, families, and advocates pointed to advance directives as an important tool in reducing involuntary treatment, including both civil commitment and the involuntary administration of medication. Specifically, these stakeholders suggested that a more robust approach to encouraging and using advance

[42] RCW §71.05.020(21)(a)(iii).

directives would permit earlier intervention consistent with the person's own wishes, rather than relying on civil commitment and other involuntary treatment approaches. In addition, many consumers objected to a provision in the law providing that advance directives will not apply when a person is civilly committed under the ITA. More research is needed to identify barriers to the use of advance directives and options for implementing them under a civil commitment order.

Training for DMHPs

Although available data does not necessarily confirm that DMHPs vary in how they apply civil commitment criteria, several stakeholders – including representatives of RSNs and the state association representing DMHPs – observed that DMHP training varies significantly from RSN to RSN. Although MHD has established statewide training protocols pursuant to §71.05.214 and provides a 40-hour basic training, the training is designed principally for new DMHPs and participation is not required. Participation in specific trainings provided by the state association representing DMHPs also is not required.

In general, RSNs serving larger populations provide independent training, but smaller RSNs have fewer available resources and the DMHPs in those areas generally are less experienced. More uniform training provided by the state should be considered to address concerns about variation in detention rates across RSNs.

IX. Next Steps

This preliminary report provides a summary of research to date and preliminary options for reform. It is anticipated that this report will be revised and refined based on input and suggestions from MHD, ongoing research, and additional input received from stakeholders and experts.

Specifically, several issues were identified for additional research in connection with the final report. They include:

1. Review available data regarding the percentage of initial detentions resulting in LRAs and variation in the use of LRAs across RSNs.
2. Review available state data regarding lengths of stay for people with developmental disabilities and other non-psychiatric disorders at state hospitals.
3. Continue to explore with a range of stakeholders why parent-initiated treatment is not used.

Conducting this research will require additional interviews with several people who already have provided input into this preliminary report.

Two additional focus groups – one of 4-8 consumers and another of 4-8 consumers and families with minor children -- are planned, and may take place either in person or by conference call in order to maximize input from individuals from the Eastern part of Washington. In addition, the following key informant interviews will be scheduled:

Joel Dvoskin, MHD Consultant to King County Forensic Work Group
Mary Zdanowicz, Executive Director, Treatment Advocacy Center
Harold (Hal) Wilson, CEO, Eastern State Hospital
Dawn Grosz, Statewide Action for Family Empowerment

A separate chapter focused on the concerns of the 29 federally recognized Tribes in Washington State with the ITA and implications of any proposed changes has been added to the scope of work for this project. Additional research will be conducted and two focus groups for Tribes will be held in April, 2007 (one in eastern Washington and one in Western Washington), and a dedicated chapter focused on these findings will be included in the final report.

Finally, the preliminary findings of this report may be presented to Task Force members either in March or April, 2007 and to a larger group of stakeholders participating in a Community Forum planned for May, 2007. Input from these meetings, as well as all additional research conducted and feedback received in connection with this project, will be incorporated into the final report submitted in June, 2007.

Appendix A

Key Informant Interviews

Sarah (Sally) Coats, J.D., Wasington Assistant Attorney General
Marilyn Deans, Western State Hospital
Deborah A. Dorfman, Washington Protection & Advocacy System
Mike Finkle, Assistant City Attorney Supervisor, City of Seattle
W. Lawrence Fitch, M.D., Director of Forensic Services, Maryland Department of Mental Hygiene
Judy Hall, Ph.D., Director of Research, DSHS Mental Health Division
Avreayl Jacobson, Tribal Liaison, DSHS Mental Health Divisionn
David Kersey, M.D., Medical Director for Mental Health Services, Seattle Jail Health Services
Ira Klein, M.D., Medical Director, Western State Hospital
Ted Lutterman, Director of Research, NASMHPD Research Institute, Inc. (NRI)
Robin McIlvaine, Children's Issues Lead, DSHS Mental Health Division (and additional MHD staff representing children's team)
Andy Phillips, Ed.D., Chief Executive Officer, Western State Hospital
Amnon Schoenfeld, King County RSN
John Tauriello, J.D., Counsel, New York Office of Mental Health
Laura Van Tosh, Director of Consumer Affairs, Western State Hospital

Focus Group Participants and Questions

12/21/06 Focus Group
Ian Harrel
Richard Lichtenstadter
Ira Klein
David Johnson
Gordon Bopp
Diana Jaden-Catori
Michael Haan
David Reed
Darcy Jaffe
Ethan Rogers
Amnon Shoenfeld
Morgan Pate
David Lord
Jill SanJule

1/17/07 Meeting with Washington Behavioral Health Inpatient Association
Will Callicoat
Mike Kerlin
Darcy Jaffe
Ann Moore
Karla Gray
Linda Crome
Edie Herman
Jackie Karsh
Ginny Buford
Carols Carreon
Shirley Goodman

1/17/07 Focus Group at Western State Hospital
Laura Van Tosh
Four individuals currently civilly committed to Western State Hospital

2/15/07 Task Force Focus Group
S. Morgan Pate
Richard Lichtenstadter
Ann Christian
Rick Weaver
Eleanor Owen
Becky Bates
David Johnson
Amnon Shoenfeld
Ethan Rogers
Bill Wilson
BJ Cooper
Chuck Benjamin
Ken Stark
Dan Peterson

Appendix B

Summary of Civil Commitment Process

The civil commitment process is described at RCW 71.05 and summarized below. An excellent discussion of the civil commitment process in Washington can be found at: Finkle, M.J. (2003). *An Introduction to the Mental Health Civil Commitment Law*. Prepared for the Snohomish County Bar Association, Everett, WA.

Petition for an initial detention. In Washington State, petitions for an initial detention are initiated by a Designated Mental Health Professional (DMHP). DMHPs are hired, employed, and often trained by Regional Support Networks (RSNs), which contract with the State to administer all public mental health services within their geographic region. The purpose of an initial detention, which can last for up to 72 hours, is to evaluate whether the individual meets specific civil commitment criteria. Initial detentions generally occur in community hospitals and do not take place either at Western or Eastern State Hospitals.

There are two ways in which a DMHP can initiate an initial detention:

1. ***Emergency petition.*** If a person is believed to present an *imminent* likelihood of serious harm, or if he or she is in *imminent* danger because of being gravely disabled, the DMHP may have the person taken into emergency custody for up to 72 hours.

2. ***Non-emergency petition*** (sometimes called the "summons process"). If the person is believed to pose a likelihood of serious harm or be gravely disabled but the danger or risk is *not* imminent, the DMHP must file a non-emergency petition with the Superior Court for the county in which the DMHP works. If the petition is granted, the Court will order the person to report to the evaluation and treatment facility for a period of up to 72 hours. If the person fails to report within 24 hours – as is usually the case – he or she may be taken into custody involuntarily.

Probable cause hearing. If the facility conducting the evaluation determines that the person meets civil commitment criteria, the facility may file a petition for either 14 days of inpatient treatment or 90 days of less restrictive alternative (LRA) treatment.

At a probable cause hearing on the petition, the facility (usually represented by county prosecutor) must demonstrate by a preponderance of the evidence that the person meets civil commitment criteria. The person has several rights at that hearing, including the right to participate in person, to present evidence, and to cross-examine witnesses. There are several possible outcomes of a probable cause hearing:

- If the court finds that the person meets civil commitment criteria, it must consider LRAs before ordering inpatient treatment. In determining whether

LRAs are appropriate, the statute requires the Court to give "great weight" to evidence of a prior history or pattern of decompensation and discontinuation of treatment resulting in repeated hospitalizations or interactions with the criminal justice system. An LRA order generally will require some form of outpatient treatment within the community for up to 90 days.

- If the court determines that an LRA is not in the best interests of the person or others, it will order inpatient treatment of up to 14 days. In general, 14-day commitments take place in evaluation and treatment facilities and do not occur at state hospitals, although some 14-day commitments take place at Eastern State Hospital.

  The statute provides that if, during the 14-day period, the professional person in charge of the facility determines that the person no longer meets civil commitment criteria, or if the person agrees to accept treatment at the facility voluntarily, the 14-day inpatient commitment must end.

- If the court finds that the person does not meet statutory criteria for civil commitment, the person will be released.

Full hearing. At the end of the 14-day period, the facility providing treatment may petition the court for an extended period of commitment. That petition is filed in Superior Court for the county in which the person is located, even if that county is different than the county in which the 72-hour detention was initiated. At the hearing, the facility will again generally be represented by the county prosecutor, although if the facility is a state hospital, it will be represented by an attorney from the state Attorney General's office.

At the hearing, the facility must prove, by "clear, cogent and convincing evidence"[43] that the person meets civil commitment criteria. If the Court agrees, then the person may be civilly committed for up to 90 days of inpatient treatment. Most, but not all, 90-day orders take place at either Western State Hospital or Eastern State Hospital. As before, the court must consider whether an LRA is in the best interests of the person and others. If so, then the court must order 90 days of treatment in the community.

Subsequent orders. At the end of the 90-day period, the person must be released unless a renewal petition is filed by the facility in Superior Court for the county in which the person is being held (generally, either Pierce or Spokane County). The commitment period under this petition and all subsequent petitions is 180 days and the standard of proof and rights of the person are the same as at the full hearing. If the 90-day order was for an LRA, the DMHP may petition for continued treatment. If the Court does not renew the commitment order, the person will be released.

Early release and conditional release. A person who is civilly committed under a 90-day or 180-day order should be released if the professional person in charge of the

[43] RCW §71.05.310.

treatment facility believes he or she no longer meets civil commitment criteria. In addition, the person may be "conditionally released" if the professional person in charge of the facility believes the person can be appropriately served by outpatient treatment. A conditional release requires Court approval and may not exceed the period of the commitment order.